Staff Health Screening Form

Date: _____ Child Care Program: _____

Please answer the following questions to the best of your ability:

Staff's Name	Do you have any symptoms of COVID-19 listed below? Y or N	Have you or anyone in the household traveled outside of ME, NH, NY, CT, NJ or VT in the past month? Y or N	Have you come into contact with anyone who has tested positive with COVID-19? Y or N	Is anyone in your household experiencing signs of illness? Y or N	Staff's temperature	Staff signature (agreeing to the information)	2nd Staff person's initials

Symptoms of COVID-19: Cough, Shortness of breath or difficulty breathing, Fever, Chills, Repeated shaking with chills, Muscle or body aches, Headache, Sore throat, New loss of taste or smell, Congestion or runny nose, Nausea or vomiting, Diarrhea